SDSU CHILDREN'S CENTER

MEDICATION AUTHORIZATION

Child's Name: _____ Date: _____

The undersigned as the parent with legal custody of the above named child, a minor, whose date of birth is _____, hereby authorize the SDSU Children's Center and any adult in their employ to administer medication to _____ under the following conditions:

NAME OF MEDICATION: _____

Method by which it is to be given: _____

Frequency: _____ and/or at the following times: _____

For treatment (describe illness): _____

Prescribed by (physician): _____ Phone: (_____)_____

Special handling/storage instructions: _____

Possible side effects we should be aware of: _____

_____

THESE INSTRUCTIONS TAKE EFFECT ON (date): _____

TO BE CONTINUED UNTIL (date or when empty): _____

I agree to inform the SDSU Children's Center Staff of any changes in the above instructions and a new Medication Authorization form will be completed.

Date: _____ Parent/Guardian Signature: _____

Date: _____ Staff Signature: _____

IMPORTANT: Before agreeing to give medication, use the medication checklist below. All items must be checked YES or the Center cannot administer the medication per CA State Licensing Regulations.

CHECKLIST FOR GIVING MEDICATION

Does the container show:

- ☐ YES ☐ NO Child's Name
- ☐ YES ☐ NO Name of medication
- ☐ YES ☐ NO Name of physician prescribing
- ☐ YES ☐ NO Times to administer
- ☐ YES ☐ NO Amount given per dose
- ☐ YES ☐ NO Method of administration
- ☐ YES ☐ NO Expiration date for contents
- ☐ YES ☐ NO ☐ NA Pharmacy's name
- ☐ YES ☐ NO How long the medication should be given
- ☐ YES ☐ NO ☐ NA Special storage instructions
- ☐ YES ☐ NO ☐ NA Does the container have childproof cap?
- ☐ YES ☐ NO Is the medication in its original container?
- ☐ YES ☐ NO Are the contents uniform?

IMPORTANT NOTE: If any of the answers to the above are no, then we cannot administer the medication.

RECORD OF MEDICATION

A dose of the medication named above was given on:

Date:	Time:	By:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This form is to be kept in a ziploc bag with the medication which is to be given to the child.
Teachers will keep a medication schedule posted in each classroom.

SDSU CHILDREN'S CENTER

MEDICATION AUTHORIZATION

Child's Name: _____

A dose of the medication named on reverse side was given on:

Date:	Time:	By: